SUMMARY OF BENEFITS

City of Albuquerque HMO

FOR QUESTIONS ABOUT BENEFITS OR SELECTING A PHYSICIAN:
Customer Care 262-7363 in Albuquerque
(800) 808-7363 outside of Albuquerque

MENTAL AND BEHAVIORAL HEALTH SERVICES ARE ADMINISTERED BY CIGNA BEHAVIORAL CARE.
For services call: (800) 698-4699

FOR ACCESS TO OUR 24-HOUR NURSE ADVICE/INFO LINE:
(800) 366-3401

For additional information visit our web site at www.lovelacehealthplan.com

LOVELACE HEALTH PLAN
You've got the right health plan.

Lovelace Health Plan provides the following benefits when Medically Necessary and only when provided or arranged by a Lovelace Health Plan participating provider. Prior authorization or referral may be required for certain services. Unless otherwise noted, copayments are due at the time of service.

COVERED SERVICES	DESCRIPTION	YOUR COST/ COPAYMENT
PRIMARY CARE PROVIDER SERVICES	Diagnosis and Treatment Preventive Care Adult Medical Care/Adult Routine Exams Well Child Care Vision and Hearing Screening (for members age 17 and under) Lab and X-ray, Routine Immunizations and Injections	$15 per visit $15 per visit $15 per visit $15 per visit $15 per visit No Charge
SPECIALTY PHYSICIAN SERVICES	Diagnosis and Treatment Lab, X-ray and Injections Diabetic Services	$25 per visit No Charge $25 per visit
ALLERGY SERVICES	Allergy Services • Testing, Treatment, and Injections	 PCP or Speciality copay applies
INPATIENT HOSPITAL SERVICES	Semiprivate Room and Board Physician and Surgeon Charges (Diagnostic and Therapeutic) Lab and X-ray Hemodialysis (member must apply for Medicare benefits) Drugs and Medications Operating and Recovery Room	$250 per admission No Charge No Charge No Charge No Charge No Charge
OUTPATIENT SERVICES	Operating and Recovery Room Physician Services Lab and X-ray Hemodialysis (member must apply for Medicare benefits) Radiation and Chemotherapy	$150 per admission No Charge No Charge No Charge No Charge
MATERNITY CARE	Pre/Post Delivery Exams All Physician and Hospital Services for mother during confinement, including, but not limited to, full term delivery, miscarriage, or termination of pregnancy Child is covered from birth but must be enrolled within 31 days	$25 for initial visit No Charge for all other routine visits $250 per admission Copayment due prior to or at time of admission Subsequent admissions related to same pregnancy – No Charge
MRI/CT/PET		$75 copayment

THESE ARE ONLY HIGHLIGHTS

This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Member Handbook and Certificate. If you have any questions about a specific service or treatment, contact Member Services at 262-7363 in Albuquerque, or (800) 808-7363 outside of Albuquerque.

COVERED SERVICES	DESCRIPTION	YOUR COST/ COPAYMENT
EMERGENCY AND URGENT CARE SERVICES	Hospital Emergency Room/ Outpatient Facility	$75 per visit
	Ambulance or other emergency transport • Ground Transportation • Air Transportation	 $50 per trip $100 per trip
	Urgent Care • All necessary services and supplies obtained at a designated urgent care facility	 $25 per visit
NON-APPOINTMENT CARE	Non-Appointment Care • Care obtained from a medical provider without having a scheduled appointment	PCP or Specialty copay
HOSPICE CARE SERVICES	Specified Hospice Care Services (which are reasonable and necessary for the palliation or management of terminal illness) • Inpatient • Outpatient	 $250 per admission No Charge
HOME HEALTH SERVICES	Prescribed home nursing care, physician and therapy care 100 visits per calendar year	No Charge
INPATIENT SERVICES AT OTHER HEALTH CARE FACILITIES	Skilled Nursing, Rehabilitation, and Sub-Acute Facilities 60 days per calendar year combined maximum	No Charge
OUTPATIENT SHORT TERM REHABILITATION	Physical, Occupational, Chiropractic and Speech Therapy[1], Acupuncture and Home Health Therapies 60 visits per calendar year combined maximum	$20 per visit
FAMILY PLANNING	Tests, Counseling Surgical Sterilization Procedures (vasectomy, tubal ligation): • Inpatient Facility Charge • Outpatient Facility Charge • Surgery in Physician's Office Norplant insertion fee	PCP or Speciality copay $250 per admission $150 per admission Office visit copay applies $100 copayment
INFERTILITY	Office Visit Treatment/Surgery – Infertility benefits are limited to services for testing, diagnosis and corrective procedures only In-vitro fertilization– Costs connected with collection, preparation, storage of sperm for artificial insemination, including donor fees Infertility Drugs	PCP or Speciality copay 50% of charges Not Covered Refer to Prescription Drug Benefit
MENTAL HEALTH SERVICES[2]	Outpatient services Inpatient services Group Therapy Partial Days	$25 per visit $250 per admission $15 per session $50 per day
ALCOHOL AND DRUG ABUSE DETOXIFICATION	Alcohol and Drug Abuse Detoxification	$250 per admission
ANNUAL OUT OF POCKET MAXIMUM	Copayments for core medical and approved benefits applicable Out of Pocket maximum is on a calendar year basis	$1500 Single/$3000 Family

[1] Speech Therapy that is not restorative in nature will not be covered
[2] To access Mental Health Services call (800) 698-4699

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EMERGENCY SERVICES are those services required to treat an accidental injury or the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain. The lack of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a Member's health, serious impairment of bodily functions, serious dysfunction of a bodily organ, or disfigurement to a person.

Outside of the Plan service area, the Health Plan pays reasonable and customary charges* for Emergency Services.

Inpatient hospitalization for any Emergency Service requires notification to the Health Plan within 48 hours of admission.

All follow-up or continuing care must be arranged through your Primary Care Provider.

EXCLUSIONS

Refer to the Lovelace Health Plan Member Handbook and Certificate for a complete listing of Plan Exclusions. Your plan provides coverage for Medically Necessary services pre-authorized by the Plan Medical Director and performed by participating providers. Your plan does not provide coverage for the following, except as required by law.

- Care by non-Plan Providers, except for services authorized by the health plan or emergencies
- Cosmetic Surgery
- Dental (coverage is available only if the optional benefits are chosen by your group)
- Drugs and medicines purchased without a doctor's prescription. Prescription drugs are covered only when your group has selected the optional drug benefit
- Durable medical equipment (DME) is covered only when your Group has selected the optional DME benefit
- External prosthetic appliances (EPA) is covered only when your Group has selected the optional EPA benefit
- Rehabilitative treatment programs for alcoholism or drug addiction, unless specifically selected as an optional benefit by your Group
- Organ transplants, except as provided in the Member Handbook and Certificate, and unless approved by the Plan Medical Director or designee
- The medical and hospital services of a donor when the recipient of an organ transplant is not a Member or when the transplant procedure is not a covered benefit
- Experimental services, investigational procedures or protocols, including drugs or equipment, except as required by law
- Care for military service-connected disabilities for which the Member is legally entitled to service and for which facilities are reasonably available to the Member
- Custodial care, including but not limited to care primarily to meet personal needs which can be provided by persons without professional skills or training. Some examples are help in walking, getting in and out of bed, bathing, dressing, eating and taking medication
- Eye refraction measurements, eyeglasses, corrective lenses, other eye appliances, hearing aids, or the fitting of either eyeglasses or hearing aids, unless specifically included as an optional benefit
- Routine physical exams, checkups, medications and inoculations and/or Biologicals required for licensing, employment, marriage, insurance or travel purposes
- Vocational rehabilitation
- Services not generally recognized as Medically Necessary, such as: HGG injections; hair analysis; transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any surgery; reversal of voluntary sterilization.
- Nursing home care, except skilled nursing services provided in a Plan approved skilled nursing facility with authorization from the health plan.
- Long-term rehabilitative therapy
- Care for conditions that State or local law requires be treated in a public facility or court-ordered services which are not ordered by the PCP and approved by the Plan Medical Director

EXCLUSIONS continued

- Repairs for Durable Medical Equipment (DME), prosthetic or orthotic devices that are owned by the Member
- Orthopedic shoes and arch supports are not covered unless they are Medically Necessary for the treatment of diabetes
- For diagnosis and non-surgical treatment of feet and bunions and routine foot care
- Expenses which an insured person would not legally have to pay if there were no insurance
- An injury or sickness due to the employment with an employer or self-employment
- For vitamins (except Medically Necessary nutritional supplements for prenatal care), minerals, food supplements (except Special Medical Foods as outlined in the Member Handbook and Certificate), dietary nutrition counseling and weight loss or exercise programs of any type

LIMITATIONS

Refer to the Lovelace Health Plan Member Handbook and Certificate for a complete listing of Plan Limitations. Your plan has limited coverage for the following services:

- Acupuncture**
- Alcohol and drug abuse benefit**
- Ambulance service**
- Chiropractic services**
- Circumstances beyond the Plan's control
- Consumable medical supplies
- Craniomandibular and temporomandibular joint (TMJ) dysfunction conditions – surgical and non-surgical treatment of TMJ is covered when Medically Necessary and authorized by the Plan Medical Director as required
- Dental care (when selected as an optional benefit by your group)
- Home health services
- Only Medically Necessary Services by a podiatrist, with prior authorization from the health plan, are covered
- For diagnosis or treatment of structural imbalance, distortion or subluxation of the vertebrae, while not confined in a hospital
- Services and benefits related to treatment of mental illness and substance abuse conditions that are not described in the Benefits and Services or Limitations sections of the Member Handbook and Certificate are excluded from coverage
- Family planning evaluational treatment services** are limited to sperm count, hysterosalpingography and endometrialbiopsy
- Private duty nurse
- Private room accommodations
- Routine physical exams**
- Substance abuse
- Tobacco cessation**
- Vision and hearing care

* Reasonable and customary refers to the rates that prevail in the area where the services are obtained. This is based on the normal charge made by most providers of such service or supply in the geographic area where the service is received.

** Your plan covers these services as required by state law. Please refer to your Member Handbook for Limitation details.

LOVELACE HEALTH PLAN
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Additional Benefits Rider
City of Albuquerque

TYPE OF SERVICE	TYPE OF COVERAGE	YOUR COST
Prescription Drugs	*A prescription is:* a maximum of a 30 day supply, a maximum of 480 ml for liquids, and the customary therapeutic regime for other products	$10 per prescription or refill for **formulary generic** drugs $35 per prescription or refill for **formulary name brand** drugs with no generic equivalent 50% of plan paid amount* for **non-formulary** drugs
	Mail Order 90-Day Supply • When obtained through the Lovelace Health Plan participating mail-order program	$20 per prescription or refill for **formulary generic** drugs $70 per prescription or refill for **formulary name brand** drugs with no generic equivalent 50% of plan paid amount* for **non-formulary** drugs
	Prescription Diabetic Supplies • Insulin, glucose test strips and other prescription diabetic supplies	Covered (copayment above)
	Birth Control • Contraceptive Devices and Oral Contraceptives	Covered (copayment above)
	Norplant Insertion Fee	Covered (refer to Summary of Benefits)
	Infertility Drugs • Oral • Injectable, Suppository	Covered (copayment above) Not Covered

Prescription Orders
You may order your prescription for up to a 90-day supply for 3 copayments at any Lovelace Sandia Pharmacy; all other pharmacies will dispense prescriptions for up to a 30-day supply.

Please check your Lovelace Health Plan Provider Directory for participating pharmacies.

Mail Order Drugs
If you take medication on an ongoing basis for a chronic condition, and your participating provider writes your prescription for a 90-day supply, you may be able to order your medication through the mail. Mail Order is convenient and economical; you obtain a 90-day supply for double the copayment listed above.

The mail order starter kit explains what drugs are covered, what to tell your doctor, and how to place orders. If you'd like more information about the Lovelace Health Plan mail-order prescription drug program or to request a starter kit, contact Member Services.

** "Plan paid amount" refers to the discounted price negotiated between Lovelace Health Plan and each participating pharmacy. This amount may vary from pharmacy to pharmacy.*

Except as otherwise set forth in this Additional Benefits Rider, coverage for Prescription Drugs is subject to the exclusions and limitations set forth in the "Limitations" and "Exclusions" Sections of the Member Handbook and Certificate.

Limitations

1. Each prescription order or refill shall be limited as follows:
   - Up to a consecutive thirty (30) day supply at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
   - Up to 480 ml for liquids; unless limited by the drug manufacturer's packaging; or
   - Up to a consecutive ninety (90) day supply at a mail order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
   - To a dosage limit as determined by the Plan Pharmacy and Therapeutics Committee (P&T Committee).

2. Coverage for Prescription Drugs includes brand name or non-formulary drugs only to the extent provided in this Additional Benefits Rider.

Exclusions

Any services or benefits related to Prescription Drugs that are not described in this Additional Benefits Rider or the Member Handbook and Certificate are excluded from coverage under the Agreement.

1. Any drugs or medications available over the counter that do not require a prescription by Federal or State Law, other than insulin, and any drug or medication that is equivalent (in strength, regardless of form) to an over the counter drug.

2. Any injectable drugs or medicines, including injectable infertility drugs, except as otherwise covered in the "Benefits and Services" Section of the Member Handbook and Certificate. However, upon prior authorization by the Plan Medical Director, injectable drugs may be covered subject to the required copayment.

3. Any drugs that are experimental or investigational, within the meaning set forth in the Exclusions Section of the Member Handbook and Certificate.

4. Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.

5. All newly FDA approved drugs, prior to review by the Pharmacy and Therapeutics committee.

6. Any prescription and non-prescription supplies (such as ostomy supplies) and devices other than syringes used in conjunction with injectable medications. Prescription contraceptive devices are covered.

7. Any prescription drugs or medications used for treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.

8. Any prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products.

9. Prescription drugs used for cosmetic purposes such as drugs used to reduce wrinkles, Minoxidil and other prescription drugs to promote hair growth as well as drugs used to control perspiration and fade cream products. Retin-A for Members over 46 years of age and other prescription products to reduce wrinkles.

10. Any diet pills or appetite suppressants (anorectics).

11. Medications and inoculations and/or Biologicals required for travel purposes.

12. Replacement of Prescription Drugs due to loss or theft.

13. Medications used to enhance athletic performance.

14. Progesterone suppositories, troche or gel

15. Medications which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premise or allows to be operated on its premises a facility for dispensing pharmaceuticals.

16. Prescriptions more than one year from the original date of issue.

LOVELACE HEALTH PLAN
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Supplemental Benefits Rider

TYPE OF SERVICES	TYPE OF COVERAGE	YOUR COST
Durable Medical Equipment	**Specified durable medical equipment** • Prescribed or ordered by a participating provider; • Approved by the Plan Medical Director; • Obtained from a vendor approved by the health plan; • Subject to the provisions and exclusions on the back of this page *Benefit maximum: Unlimited*	50% of charges

DME 50% UNLIMITED

SUPPLEMENTAL BENEFITS RIDER
DURABLE MEDICAL EQUIPMENT

Except as otherwise set forth in this Supplemental Benefits Rider, coverage for Durable Medical Equipment is subject to the limitations and exclusions set forth in the "Limitations" and "Exclusions" Sections of the Member Handbook and Certificate.

Definition of Durable Medical Equipment

Durable Medical Equipment is defined as: items that can withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; and are not disposable. Such equipment includes crutches, hospital beds, wheel chairs, respirators, oxygen tents and dialysis machines.

Services and Benefits

Coverage will be provided for the purchase or rental of Durable Medical Equipment when:

- Ordered or prescribed by a participating provider;
- Approved by the Plan Medical Director; and
- Provided by a vendor approved by the Health Plan.

Exclusions

Any services or benefits related to Durable Medical Equipment that are not described in this Additional Benefits Rider are excluded from coverage under the Plan. The following exclusions shall not apply to durable medical equipment determined to be a medical necessity (as defined in the "Definitions" Section of the Member Handbook and Certificate) if provided in connection with the services described in the "Inpatient Rehabilitative Facilities" or "Home Health Services" provisions of the Member Handbook and Certificate.

- Hygienic or self-help items or equipment, or items or equipment that are primarily for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed-tables, saunas or exercise equipment
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines
- Institutional equipment, such as air fluidized beds and diathermy machines
- Consumable medical supplies including, but not limited to bandages and other disposable supplies, skin preparations, ostomy supplies, surgical leggings, elastic stocking and wigs
- Penile prostheses
- Equipment used for activities including, but not limited to, braces and splints
- Items which are not generally accepted by the medical profession as being therapeutically effective, such as auto tilt chairs, paraffin bath units and whirlpool baths

LOVELACE HEALTH PLAN
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Supplemental Benefits Rider

TYPE OF SERVICES	TYPE OF COVERAGE	YOUR COST
External Prosthetic Appliances	**Specified external prosthetic appliances** • Approved by the Health Plan • Subject to the provisions and limitations on the back of this page *Benefit maximum: $1,000 limit per calendar year*	No charge after $200 deductible

SUPPLEMENTAL BENEFITS RIDER
EXTERNAL PROSTHETIC APPLIANCES
DEDUCTIBLE OPTION

Except as otherwise set forth in this Supplemental Benefits Rider, coverage for External Prosthetic Appliances is subject to the limitations and exclusions set forth in the "Limitations" and "Exclusions" Sections of the Member Handbook and Certificate.

Services and Benefits

Coverage will be provided for the initial purchase and fitting of an External Prosthetic Appliance:

- Which is used as a replacement or substitute for a missing body part
- Which is necessary for the alleviation or correction of illness, injury or congenital defect

External Prosthetic Appliances shall include artificial arms and legs and terminal devices such as a hand or hook. Replacement of an External Prosthetic Appliance is covered *only* if necessitated by normal anatomical growth.

Exclusions

Any services or benefits related to an External Prosthetic Appliance that are not described in this Additional Benefits Rider are excluded from coverage under the Plan.

By way of example, but not limited to, the following are specifically excluded services and benefits:

- Any biomechanical devices
- Any devices that are experimental or investigational, within the meaning set forth in the "Limitations" Section of the Member Handbook and Certificate
- Replacement of External Prosthetic Appliances due to wear and tear, loss, theft or destruction

LOVELACE HEALTH PLAN
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Additional Benefits Rider

Vision Benefits – High Option

TYPE OF SERVICE	TYPE OF COVERAGE	PLAN PAYS
Eye Exam	One complete eye examination is covered every calendar year through participating providers.	Balance after **$5 member copayment**
Contact Lenses	One pair per calendar year through participating providers.	$75
OR		
Eyeglasses:	One pair per calendar year through participating providers.	
Frames	One pair per calendar year	$30
Lenses	One Pair of Single Vision Lenses, or One Pair of Bifocals, or One Pair of Trifocals	$20 $30 $40

- Coverage for one pair of eyeglasses OR one set of contact lenses every calendar year
- Lenses include all powers, including prescribed prism, and slab-off, myodisc, etc.; choice of crown glass or CR 39 (plastic); all eyesizes; Bifocal style ST-25, 28 round; Trifocal style ST-25; Aphakic style, Standard styles.
- Includes lenses that are glass, plastic, tinted, and have scratch resistant and/or ultraviolet protection.
- It is the responsibility of the member to pay for all charges that exceed what the Plan pays.

Please refer to the Lovelace Health Plan Provider Directory for participating providers.

ADDITIONAL BENEFITS RIDER
VISION BENEFITS

Except as otherwise set forth in this Additional Benefits Rider, coverage for Vision Care Services are subject to the limitations and exclusions set forth in the "Limitations" and "Exclusions" Sections of the Member Handbook and Certificate. In addition, any services or benefits related to vision care that are not described in this Additional Benefits Rider are excluded from coverage under the Plan.

Exclusions

By way of example, but not limited to, the following are specifically excluded services and benefits:

- Any services or items related to orthoptics or vision training
- Magnification vision aids
- Any non-prescription eyeglasses, lenses or contact lenses
- Any charges for anti-reflective coatings, prescription sunglasses or light sensitive lenses
- Any eye examination required by an employer as condition of employment or which an employer is required to provide under a collective bargaining agreement
- Any court-ordered eye examination
- Safety glasses or lenses required for employment

LOVELACE HEALTH PLAN
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Supplemental Benefits Rider

Substance Abuse Benefits – City of Albuquerque

Substance abuse benefits are administered for Lovelace Health Plan by CIGNA Behavioral Health (CBH). You access care by calling ***(800) 698-4699.*** *All care must be pre-authorized.*

TYPE OF SERVICES	TYPE OF COVERAGE	YOUR COST
Substance Abuse	**Outpatient Services – Substance Abuse/Alcohol Dependency** • 20 visits or one program per calendar year maximum (an additional 10 visits available for alcohol dependency coverage)	$25 per visit
	Group Therapy • 40 sessions per calendar year maximum	$15 per session
	Inpatient Services • 30 days per calendar year maximum	$50 per day
	Partial Hospitalization • Two partial hospitalizations equal one inpatient day	$25 per day

Substance Abuse

Substance abuse benefits are administered for Lovelace Health Plan by CIGNA Behavioral Health (CBH). You access care by calling 800.698.4699. All care must be pre-authorized.

In a non-emergency situation, the first step is usually a confidential appointment with a counselor who will meet with you and assess the best next steps to take. After the assessment, if the appropriate next step is treatment, our professional staff members at Lovelace and CBH will provide confidential assistance, counseling, or treatment for problems that threaten the stability of your life, at home or at work. Or, they will refer you to a specialist in your community.

Emergency calls will be immediately guided to a professional for crisis assistance.

For inpatient admission, call **(800) 698-4699** in advance for pre-authorization. For emergency admission, call this toll-free number by the end of the next business day following emergency admission.

Substance Abuse Services Include:

- Diagnostic assessments
- Intensive outpatient treatment
- Family counseling
- Referral to other necessary treatment programs.

For more information, please call Lovelace Health Plan Member Services at 262-7363 in Albuquerque or (800) 808-7363 outside of Albuquerque, or CIGNA Behavioral Health at (800) 698-4699.

SUPPLEMENTAL BENEFITS RIDER
SUBSTANCE ABUSE SERVICES
CITY OF ALBUQUERQUE

Except as otherwise set forth in this Supplemental Benefits Rider, coverage for treatment of substance abuse is subject to the limitations and exclusions set forth in the "Limitations" and "Exclusions" Sections of the Member Handbook and Certificate. In addition, any services or benefits related to the treatment of substance abuse that are not described in this Supplemental Benefits Rider are excluded from coverage under the Plan.

Inpatient Substance Abuse Rehabilitation Services

Coverage will be provided for inpatient Substance Abuse Services for up to 30 days per calendar year for rehabilitation when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs and when authorized by the health plan. Coverage for inpatient services are subject to the copayments listed on this Supplemental Benefits Rider.

Outpatient Substance Abuse Rehabilitation Services

Coverage will be provided for outpatient Substance Abuse Services in an individual, group or structured group therapy program, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs and when authorized by the health plan. Such services are limited to 20 individual sessions (an additional 10 visits available for alcohol dependency coverage), or 40 group sessions per calendar year, or one structured program per calendar year. A Member shall also be entitled to outpatient testing and assessment, when authorized by the health plan. Coverage for outpatient services are subject to the copayments listed on this Supplemental Benefits Rider.

Exclusions

By way of example, but not limited to, the following are specifically excluded services and benefits:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless such order is being sought by a Plan Provider
- Long-term rehabilitative therapy